South Dakota Health Home Program

Basics
What is a Health Home?

- Partnership with Medicaid providers to help manage the high cost high risk recipients.
- Team based approach that deals with the whole person.
- This approach is designed to affect change in a Health Home recipient’s health status and to reduce utilization of high cost services.
- Six Core Services outlined by CMS and defined by the Health Home Workgroup must be provided to each Health Home recipient at the appropriate level.

Provider Infrastructure

**Primary Care**
- Primary Care Physicians
- PAs
- Advanced Practice Nurses
  - Federally Qualified Health Center
  - Rural Health Clinic
  - Clinic Group Practice
  - IHS

**Behavorial Health**
- Mental Health Providers
  - Community Mental Health Centers

**Health Care Team**
- Care Coordinator/Health Coach
- Case Manager
- Community Support Provider
- Pharmacists
- Support staff
- Other appropriate services
Who do Health Homes serve?

• **Any** Medicaid recipient who has...
  - Two or more chronic conditions OR one chronic and at risk for another (Defined separately):
    - **Chronic conditions include**: Mental illness, substance abuse, asthma, COPD, diabetes, heart disease, hypertension, obesity, musculoskeletal, and neck and back disorders.
    - **At risk conditions include**: Pre-diabetes, tobacco use, cancer, hypercholesterolemia, depression, and use of multiple medications (6 or more classes of drugs).
  - One severe mental illness or emotional disturbance.
• Eligibility based on 15 months of claims data based on diagnosis.
• Medicaid recipients that meet criteria are stratified into four tiers based on the recipient’s illness severity using CDPS (Chronic Illness and Disability Payment System).

Provider Capacity

• Current Number of Health Homes – 128 serving 132 locations
  - FQHCs = 24
  - Indian Health Service Units = 11
  - CMHCs = 9
  - Other Clinics = 84
• Around 700 designated providers.
• Average around 5,800 recipient in the program per month.
Six Core Services

• CMS requires the six Core Services be provided to all recipients attributed to a provider.

• Health Homes are paid on a quarterly basis a retrospective monthly PMPM for the delivery of the Core Services. All medical services continue to be reimbursed according to the current reimbursement structure.

• Health Home minimum requirement is to provide one of the Core Services to each recipient every quarter

• Core services must meet these basic criteria:
  ▪ Recipient is engaged in the service but it does not need to be in person
  ▪ Service ties to the care plan
  ▪ Service is documented in the EHR
  ▪ Service has not already been billed to South Dakota Medicaid using a fee for service, encounter or daily rate.

Six Core Services

• Six Core Services must be provided to the level appropriate for each recipient. More in depth definitions at:

  http://dss.sd.gov/docs/medicaid/pcpcoreservicesspecificfinalforweb.pdf

  1. Comprehensive care management
  2. Care coordination
  3. Health promotion
  4. Comprehensive transitional care/follow-up
  5. Patient and family support
  6. Referral to community and social support services
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Results

Health Homes Transform Care

Health Homes change the way Medicaid recipients receive care by creating a person centered care team to meet the needs of the patient.
Health Homes increase Preventive and Primary Care

- A team based model takes pressure off of the Primary Care Provider, by allowing members of the team to help the recipient.

- Preventive Care remains stable or continues to show improvements.

![Graph showing improvements in preventive care](image)

Improving Outcomes

- The Conditions which make a recipient eligible have an outcome measure.

- Outcome Measures are reviewed in two different ways.
  - Calendar Year to Calendar Year to show a change in provider behavior.
  - Results based on the length of time the recipient is in the program to show improved health.

<table>
<thead>
<tr>
<th>Skeletal and Connective Disorders</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Back Conditions</td>
<td>39.2%</td>
</tr>
<tr>
<td>Musculoskeletal Conditions</td>
<td>6.9%</td>
</tr>
<tr>
<td></td>
<td>of enrolles</td>
</tr>
</tbody>
</table>

- Increase % of individuals with a diagnosis of chronic pain that have a pain management plan.
- Increase % of individuals with HbA1c under control.
- Increase % with blood pressure in control.

![Graph showing improvements in outcomes](image)
Improving Outcomes

- Measures also display the percentage of individuals who have the condition along with the goal.

<table>
<thead>
<tr>
<th></th>
<th>Cardiovascular</th>
<th>Obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>24.5% of enrollees</td>
<td>22.5% of enrollees</td>
</tr>
<tr>
<td>Hypertension</td>
<td>50% of enrollees</td>
<td></td>
</tr>
</tbody>
</table>

**Health Management: Caring for People in the Most Cost-Effective Manner**

- **Health Homes – Estimate of Avoided Costs**
  - In CY 2018, HH recipients cost $226 less per month than recipients who looked like them. The Health Home Matched Analysis showed that the Health Home program avoided costs for the Medicaid program for CY 2018. $7.3 Million after PMPMs and Quality Incentive Payments.
Health Management: Caring for People in the Most Cost-Effective Manner

- **Health Homes – Estimate of Avoided Costs by Type of Service**
  - In CY 2018, DSS found that 70% of costs avoided are due to decreased inpatient admissions, emergency room use. Pharmacy and all other expenditures resulted in the remaining 27%. Physician services accounted for an increase of approximately $50,000.

![CY2018 Cost Impacts by Expenditure Category](image)

- **Health Homes – Estimate of Avoided Costs by Tier**
  - In CY 2018, Tier 2 recipient made up a majority of the avoidance, Tier 3 and 4 made up 41% of the avoidance while Tier 1 recipients cost 5% more than their counterpart not in the program.
Health Home Outcome Measures Results

- Data Dashboard has full results of outcome measures at

- Our Health Home Data Dashboard was recently updated with CY 2018 information and contains other exciting information, such as success stories, about the program.


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Performance Rewards
Performance Rewards

- Since the inception of the Health Home program, rewarding Health Homes for their success has been part of the dialogue.
- The State has always been support of this concept, but needed to wait for the program to prove itself and find a method that CMS would approve.
- The Medicaid State Plan allows Quality Incentive Payments to be made when the cost avoidance exceeds $3 million.
- As demonstrated above Health Homes continue to exceed this amount even as PMPMs are inflated and Quality Incentive Payments are made.

Performance Rewards

- The Legislature provided just under $1 million to reward Health Homes for their performance in the 2018 Legislative Session.
  - 50% of the money went to everyone by increasing PMPM around 16%. Took effect for the January–March 2018 quarter.
  - Remaining 50% went to Quality Incentive Payments. Methodology created in concert with a Subgroup of the Implementation Workgroup.
    - Payment for clinics with an average caseload of 15 or less to incentivize participation.
    - Outcome measures as it relates to the state average.
    - Case Mix.
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Questions and Thank You!